

Exhibit C

Daniel Adler, MD, L.L.C.

Specializing in Pediatric Neurology

119 West 57th Street ◦ Suite 600 ◦ New York, NY 10019
Tel: 201.894.1551 ◦ Fax: 212. 504.8100 ◦ drdanadler@cs.com

November 19, 2021

Randolph D. Janis, Esquire
Douglas & London
59 Maiden Lane
The Sixth Floor
New York, NY 10038

RE: G [REDACTED], U [REDACTED]

Dear Mr. Janis:

I have reviewed the following records and documents that pertain to the above-named child:

1. Prenatal records from the Charles B. Wang Community Health Center;
2. Labor & delivery records from New York Presbyterian Hospital Lower Manhattan Hospital dated October 2, 2018;
3. Newborn records from New York Presbyterian Hospital Lower Manhattan Hospital dated October 2, 2018;
4. Records from South Bronx Pediatrics;
5. Deposition transcript of Sandy Bui, M.D.; and
6. Deposition transcript of Asseta Nanema.

Asseta Nanema is the mother of U [REDACTED] G [REDACTED]. She was pregnant in 2018. She received prenatal care at the Charles B. Wang Community Health Center. Asseta Nanema was 30 years of age at that time.

Asseta Nanema was hospitalized at the New York Presbyterian Hospital Lower Manhattan Hospital on October 2, 2018. She was at 38 weeks gestation. She was in labor. The delivery note indicates that Ms. Nanema was fully dilated and pushed for two hours. The fetal heart monitoring was recorded as category 2. The delivery note goes on to say, "Vaginal delivery of viable male infant, ROP, shoulders and body delivered atraumatically, Apgar 7/8, weight 3570 grams." The delivery note does not discuss any abnormalities of the baby's arms.

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After discharge from the hospital, U ■■■ G ■■■ received care from the pediatricians at South Bronx Pediatrics. Contained within their records are notes from other healthcare providers.

The pediatricians provided Umar with routine care.

At the referral of the pediatricians, U ■■■ G ■■■ was seen at Bright Start PT and PTA Early Intervention. They provided him with various therapies.

The pediatricians at South Bronx Pediatrics also referred U ■■■ Gu ■■■ to Dr. Leonard Haas. Dr. Haas saw U ■■■ when he was 10 days of age. Dr. Haas' examination was consistent with what was observed in hospital. He noted weakness in the right upper extremity. He offered the diagnosis of "Erb's palsy."

The date of that visit was November 9, 2018.

Dr. Devorah Segal is a pediatric neurologist. She saw U ■■■ G ■■■ and was in general agreement with the note of Dr. Haas.

U ■■■ G ■■■ also received therapies at Motion Sports Medicine in the Bronx, New York.

Dr. Sandy Bui is an obstetrician. She was the doctor who delivered U ■■■ G ■■■ She provided deposition testimony. In her deposition, Dr. Bui indicated that she did not believe that any traction supplied to the infant's head was excessive because "as soon as the infant's head came out, the shoulder came out spontaneously as well."

Asseta Nanema is the mother of U ■■■ G ■■■. She provided deposition testimony. She indicated that during the birth, the doctor was "pulling up so strongly that I moved from the bed down." She further stated that the doctor was "pulling the baby until I slipped a little bit from the bed." She stated, "He was really strong."

In her deposition, Ms. Nanema described the problems that her son was having which included difficulties with sports and dressing. She indicated that U ■■■ "can't eat with his right hand." She stated that when you see her son "you will understand right away that he's handicapped."

I saw U ■■■ G ■■■ in pediatric neurological consultation on October 12, 2020. U ■■■'s date of birth is ■■■■ 2018. He is now 2 years of age. His mother is Asseta Nanema. She brought U ■■■ to the office. Prior to seeing Umar, I had an opportunity to review medical records. These medical records indicate that U ■■■ weighed 3,570 grams at

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his birth. His Apgar scores were 7 and 8 at one and five minutes respectively. The delivery note indicates that he was positioned in the right occiput posterior position and specifically says, "Shoulders and body delivered atraumatically." U ■■■'s birth occurred at 38-39 weeks gestation.

After delivery, it was noted that U ■■■'s right arm was weak. His grasp was weak as well. There was evidence of bruising in the right arm. X-rays revealed no bony abnormalities and no fractures. U ■■■ did not improve prior to discharge. The diagnosis was Erb's palsy.

After delivery, U ■■■ G ■■■ saw pediatric neurologists at Weill Cornell Medical Center. The first visit occurred when he was 10 days of age. At that time, U ■■■ was being evaluation for early intervention. The examination revealed weakness of the right upper extremity. There was slight weakness in the right hand. According to the pediatric neurologist, the arm was in the "classic Erb palsy posture."

U ■■■ received care and treatment from Bright Start Physical Therapy. When U ■■■ was 6 months of age, they noted improvement. At that time, U ■■■ was able to actively externally rotate his arm and supinate his forearm.

U ■■■'s mother told me that he has not seen doctors who specialize in the care and treatment of brachial plexus injury. She told me that he did receive various therapies through an early intervention. There was a short hiatus because of COVID-19. She told me that she will be initiating therapy again soon.

U ■■■ is a boy who walked by 1 year of age. He is beginning to speak words in English and in French, which is a language spoken in the house. U ■■■ has no other healthcare concerns.

The general physical examination reveals a pulse of 100 and respirations of 20. There are no skin lesions of neurological significance. The head, ears, eyes, nose, and throat are negative. The neck is supple. The thyroid gland is not enlarged. The heart and lungs are unremarkable. The back is straight. The right arm is held with the shoulder depressed and internally rotated. The elbow is flexed and the hand is pronated. There is scapula winging on the right. There is a positive trumpet sign at 90 degrees on the right. Measurements of both upper extremities could not be performed. By appearance, the right is shorter than the left arm.

I measured passive range of motion. I produced the passive movements. The results are in the following chart:

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Passive Range of Motion	Right Upper Extremity	Left Upper Extremity
Shoulder flexion	170 degrees	180 degrees
Shoulder extension	45 degrees	60 degrees
Shoulder horizontal abduct.	150 degrees	180 degrees
Shoulder external rotation	75 degrees	90 degrees
Shoulder internal rotation	45 degrees	60 degrees
Elbow flexion/extension	150 degrees/10 degrees	150 degrees/0 degrees
Forearm supination	0-180 degrees	0-180 degrees
Forearm pronation	0-180 degrees	0-180 degrees
Wrist extension	0-90 degrees	0-90 degrees
Wrist Flexion	0-90 degrees	0-90 degrees
Finger flexion/extension	Normal	Normal

The neurological examination revealed a boy who was friendly and cooperative. I did not hear him speak in sentences. There is symmetrical movement of the face and tongue. Extraocular movements are full. There is no Horner's syndrome. Muscle tone is decreased. Due to his age, U ■■■ was not able to cooperate fully for active range of motion testing. It was clear the movements of the right arm are abnormal. He does not fully elevate that arm above his head. He cannot fully straighten that elbow actively. He does not supinate the right forearm. Finger and thumb movements appear normal. There are no reflexes in the right arm. Reflexes in the left arm are 1+. Reflexes in the legs are 1+. U ■■■ has a normal gait for his age. Manual muscle testing was not performed.

CLINICAL IMPRESSION: 1. Brachial plexus injury involving the 5th and 6th cervical nerves on the right with incomplete recovery.
2. Shoulder contracture, right.
3. Elbow contracture, right.

FORMULATION: U ■■■ G ■■■ is a boy with permanent neurological disabilities as a result of a neonatal brachial plexus injury involving the right arm. My examination demonstrated a pattern of abnormalities that indicates the fifth and sixth cervical nerves have been injured.

Because of his permanent neonatal brachial plexus injury, U ■■■ G ■■■ will require physical and occupational therapies until he reaches the age of skeletal maturity. Skeletal maturity typically occurs in males by 18 years of age but can be delayed until their 21st year of life.

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Because of his permanent neonatal brachial plexus injury, U ■■■ G ■■■ has one of the typical orthopedic consequences of a permanent brachial plexus injury, an internal rotation contracture of the right shoulder. This condition can often require extensive treatment, which can include multiple surgeries and injections of botulinum toxin.

There is an elbow contracture of the right elbow. This condition can also often require extensive treatment.

While these additional treatments may allow U ■■■ G ■■■ to function better, his ability to perform certain activities of daily living will still be limited. His inability to internally rotate his right shoulder will affect activities such as washing and dressing. For example, it will be difficult for U ■■■ G ■■■ to pull up or button his pants, tie his shoes or comb his hair.

Later in life, U ■■■ G ■■■'s opportunities in the competitive job market will be restricted by the problems with his arm. "Blue collar" types of jobs may be impossible to perform for a person like U ■■■ G ■■■ who has a permanent disability involving an arm. For example, any job that requires heavy lifting and carrying, or elevation of the arms above the head will be impossible. Sustained bimanual tasks will be impossible. Additional therapy and surgery will not change his employability.

There is already a discrepancy in the length between the left and right arms. As U ■■■ G ■■■ grows and matures and enters puberty, there will be a discrepancy approaching 10% in length between the affected right and left arm. This will create a significant cosmetic deformity.

With respect to causation, neurological textbooks and literature outline the potential causes of permanent neonatal brachial plexus injury. There are medical conditions such as cancer or infection that can directly injure the nerves that comprise the plexus. When underlying medical conditions are excluded, the cause of permanent neonatal brachial plexus injury to the right arm present at delivery is traumatic tearing of nerves. This tearing occurs as a result of a forceful stretch of those nerves beyond the point of structural failure (plastic limit) as the head of the baby is moving laterally or rotates away from the right arm.

In this case, where the aforementioned medical conditions are not defined in the medical records, the permanent brachial plexus injury in the right arm suffered by U ■■■ G ■■■ was caused by traumatic tearing of the nerves of the brachial plexus.

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Rarely, the stretching of the nerves of neonatal brachial plexus injury can be exaggerated when the fetus has muscle atrophy in the head and neck or suffers intrapartum hypoxia sufficient to cause fetal hypotonia and acidosis. U ■■■ G ■■■ had none of these conditions.

It is my medical opinion the degree of forceful stretch of the nerves required to produce the traumatic neonatal brachial plexus injury seen in this case occurred after the head of U ■■■ G ■■■ was delivered during the movement of the head away from the injured right arm created by the obstetrician.

It has been argued by some that permanent traumatic neonatal brachial plexus injury occurs with movement of the fetal head created by the forces of uterine contraction along with the mother pushing during labor and before any physician efforts to deliver the fetus.

It is my medical opinion the maternal forces of labor have never been proven to be the cause of a permanent neonatal brachial plexus when the fetus does not have exaggerated risk of nerve stretch. Experimental studies performed on neonatal nerves suggest the force required to physically disrupt the fifth cervical nerve is at least 44 to 88 lbs. Experimental studies suggest the forces of labor do not reach these levels and therefore do not cause permanent brachial plexus. In fact, the actual forces of labor were not measured in this case.

When the injured shoulder is not positioned anteriorly under the pubic bone but located posteriorly as in this case, some will argue this is proof the brachial plexus injury must have occurred on an intrauterine basis. This is because the direction the fetal head is moved by the obstetrician to facilitate delivery of the fetal body is typically down. In this case, neither the directional movement of the fetal head nor the angle of head movement off axis created by the operator are described in the medical records.

It is therefore my medical opinion that the fetal head in this case was moved in an upward direction by the obstetrician after it delivered. Upward movement of the fetal head do occur during the efforts to deliver the fetal body. Ankumah and others wrote that after emergence of the fetal head there is "manipulation of the head downward, upward, and possibly laterally; traction utilized."

It is also my medical opinion that traumatic injury to U ■■■ G ■■■'s brachial plexus could therefore have been avoided if the delivery could have been accomplished by the obstetrician with little to no movement of the head, thus limiting the amount of forceful stretch of the nerve roots.

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All of the aforementioned disabilities, limitations and special needs are a direct result of U ■■■ G ■■■'s brachial plexus injury and the resulting permanent and continuing neurological injuries. All of the treatment provided to U ■■■ G ■■■ as a result of these permanent and continuing neurological disabilities has been medically necessary and appropriate.

I reserve the right to amend, modify, or otherwise supplement my opinions should additional material become available or there is a change in circumstances.

These opinions are provided with a reasonable degree of medical probability.

Sincerely yours,

A handwritten signature in black ink, appearing to read 'Daniel Adler', with a stylized, cursive script.

Daniel Adler, M.D.

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